

New Patient History Form

DATE: _____

Name: _____ Date of birth: _____ Age: _____ Sex: M F

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Restrictions? _____ Cell / Pager #: _____

Employed: Yes No Status: Full Part-time Retired

Work Phone: _____ Can we call you at work? _____

Are there any phone restrictions? _____

Can we leave a message at home? Yes No ...at work? Yes No ...on cell? Yes No

Occupation: _____

Employer: _____

Social Security # _____ Driver's License # _____

Reason for visit: _____

Personal History

Marital Status: Single Live-In-Partner Married Remarried Separated Divorced Widowed

Partner's Name: _____ Age: _____ Employer: _____ Occupation: _____

Emergency Contact Person: _____ Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Address: _____

Student Status: Full Part-time None School: _____

Permanent Home Address: _____

Medical History

Referred by: _____ Phone: _____ Primary Care Physician: _____

Are you presently seeing a therapist or counselor? Yes No Name: _____

Have you seen a psychiatrist within the past 12 months? Yes No

Medical Conditions: _____

Current Medications: _____

Are you allergic to any medications? Yes Unknown If so, names: _____

Insurance Information

Primary Ins: _____ Policy Holder: _____ Relationship to Pt: _____

PH DOB: _____ PH SS#: _____ Policy #: _____ Group #: _____

Secondary Ins: _____ Policy Holder: _____ Relationship to Pt: _____

PH DOB: _____ PH SS#: _____ Policy #: _____ Group #: _____